# http://intra.sahs.sa.gov.au/public/download.jsp?id=96206&showOrig=t

 Patient details

|  |  |
| --- | --- |
| UR number |  |
| Surname |  |
| Given Name |  |
| DOB |  |

 Or affix label

# SALHN Lymphoedema Clinic

# Referral Form

Please fax completed form to **8204 3040**

Please ensure **all** sections are completed and form signed by a medical practitioner.

If information is missing or inadequate, the form will be returned to the referrer, delaying the process.

At this stage we are unable to provide a service for patients

* who have a WorkCover or other outstanding compensation claims in relation to their lymphoedema
* who are not Medicare eligible
* who are currently receiving treatment for their lymphoedema by another provider (public or private)
* who live outside the SALHN catchment area

**Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Address |  | Does patient identify as Aboriginal or Torres Strait Islander | Yes □No □ |
| Phone (h) |  | Interpreter required? | Yes □No □ |
| Mobile phone  |  | Type of Interpreter required |
| Medicare number |  | Is the patient a permanent resident of South Australia? | Yes □No □ |

**Referring Practitioner**

|  |  |
| --- | --- |
| Print name |  |
| SALHN clinic name |  |
| Practice name and address if external referral |
| Clinic phone number | Email address |

**Reason for Referral**

|  |  |
| --- | --- |
| Diagnosis |  |
| Primary lympoedema □Secondary lymphoedema □ | Date of onset (if known) ……./……../…….. |
| Location of oedema | Right arm □ Left arm □ Bilateral □Right leg □ Left leg □ Bilateral **□**Genital □ Head & Neck □ |
| Cause of the secondary lymphoedema |  |
| Previous investigation for the lymphoedema(Please specify) |  |
| Previous treatment for the lymphoedema yes □ No □ | Details (if known) | Name of provider (if known)  |
| Additional information regarding this referral |  |
|  |
| **Cancer history if relevant**  |
| Previous cancer treatment Radiotherapy (include location and date) Chemotherapy ( current or previous now ceased) |  |
| Past Medical HistoryDiabetes yes □ No □Deep venous thrombosis yes □ No □Peripheral arterial insufficiency yes □ No □Has had Ankle Brachial Index test yes □ No □Chronic venous insufficiency yes □ No □Heart disease or cardiac failure yes □ No □Unstable renal failure yes □ No □Endocrine disorder yes □ No □Low serum albumin levels yes □ No □Trauma yes □ No □Other ………………………………………….. | If answered yes to any, please provide details (including date and outcome of the ABI test if relevant) |
| Past Surgical history |
| Current medication(s) |
| Allergies  |  |
| Patient current weight …………kgPatients Height ………..cm |  |
| Social history and supports availableDoes this patient live with a partner/ carer? |  |

I confirm that the above information is true and accurate.

I confirm that the patient has a clinical diagnosis of lymphoedema.

Medical Officer Signature …………………………………………………………………………. Date ………/………/……..